Homeless Families Pilot Project Evaluation

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EXECUTIVE SUMMARY

Overview

The Los Angeles County Board of Supervisors has established an interagency Homeless Families Pilot Project in order to respond to the needs of CalWORKs-eligible homeless families in which a parent has mental health problems.

The Board has funded the project in three phases.

- Phase One (initial pilot): In 2002 the board established an initial pilot project located in the "skid row" area to serve 26 homeless families that included a parent who had mental health problems. Interagency partners included the Department of Public Social Services (DPSS), the lead agency, the Department of Mental Health (DMH) and the Los Angeles Homeless Services Authority (LAHSA).
- Phase Two (two sites): In September 2003, the board approved a resolution calling for two pilot projects—a continuation of the one in skid row and one in the San Gabriel Valley—to serve 20 clients each. The skid row project operates out of the Downtown Mental Health Clinic, and the San Gabriel Valley project is located at the PROTOTYPES clinic.
- Phase Three (expansion): The two existing sites were expanded and an additional four sites were added in the spring of 2005. The skid row site has 100 participants and each other site has 50 participants for a total of 350 families. Each supervisorial district contains one site.

At the request of the Board of Supervisors, the Department of Mental Health contracted with the California Institute for Mental Health (CIMH) to conduct an evaluation of the outcomes of the 40 participants served in 2003-2004. The contract has since been modified so that CIMH is also evaluating the expanded 350 participants program.

This report presents service outcomes from Phase Two (two sites) and describes the service model as it has evolved in all three phases, through April 2005.

Methodology

Data are drawn from clinician ratings throughout the project, DMH and DPSS electronic records, and a research interview with participants conducted approximately one year after admission to the program. Information on the service model stems from extensive interviews with staff and administrators.

Major findings

The service model

- Key elements of the service model appear highly effective, particularly the interagency collaboration, the use of both clinical and case management staff, and the improved access to Section 8 vouchers.
- While Section 8 vouchers seem critical to success, they take time to obtain, not everyone qualifies, and there remain difficulties in finding and obtaining qualified housing within the 90 days allowed by Section 8.

Primary outcomes

- The program had significant but limited success (35%) in obtaining rental housing for clients; however, over half of the participants were still receiving services in May 2005 and may yet be successful in achieving permanent housing.
- Stability of housing is associated with improved participant mental health status.
- Mental health status and functioning in daily living improved somewhat, but improvement was not found on all measures—in part because participation in therapy was not consistent for almost half of the participants.
- Clients are generally rated by therapists as good parents, and their capacity to parent improved during the program.
- Despite project services, parents at follow-up interviews reported not always being able to get medical and dental care for their children and that they sometimes did not have enough food.
- The number of school changes was reduced for children in the project compared to the previous year.

- About 45% of participating parents worked during the study period, and staff considered the capacity to work of most participants to have improved during the program.

Secondary outcomes

- About a third of the parents had serious functional limitations due to health conditions.
- Domestic violence was a problem for 12 mothers.
- A learning disability is likely for almost one third of the participants, and these persons report more disability days and fewer job skills.
- Despite receiving assistance with transportation, it remains a significant barrier to obtaining services, maintaining children in school, and finding employment.

The broader context

- Most participants became homeless for economic reasons.
- A substantial number of additional families meet the criteria for the pilot project. We estimate between 1,000 and 3,400 families receiving CalWORKs are homeless in a year. If eligibility requirements were less stringent, many other homeless families would qualify.

Efforts to achieve long-term housing and employment are now coming up against system issues which are beyond the scope of the pilot project service model. These system issues include limited short-term housing for families, limited housing vouchers, and a growing discrepancy between welfare income or income from low-wage jobs and the costs of rental housing suitable for families.

RECOMMENDATION

Program funding should be continued through June 2006.

All of the interviewed pilot project staff believe that it takes at least one year of intervention for clients to have a reasonable chance of achieving permanent housing and employment goals. The results of this evaluation confirm that a program length of only six to twelve months reduces the likelihood of positive outcomes. The current Phase Three program is scheduled to be funded only until December 30, 2005, with subsequent funding dependent on state allocations. Since most participants did not become enrolled until March 2005, or later, this would mean they will receive services for less than a year. Because this program is resource-intensive, it is prudent to continue operating for a sufficient length of time to allow for a meaningful evaluation. We therefore recommend that program funding be continued through June 2006.

PART 1: THE HOMELESS FAMILIES PILOT PROJECT IN CONTEXT

Background of the project

The Los Angeles County Board of Supervisors has established an interagency Homeless Families Pilot Project in order to respond to the needs of CalWORKs-eligible homeless families whose parent(s) have mental health problems.

The Board has funded the project in three phases.

- Phase One (initial pilot): In 2002 the board established an initial pilot project located in the "skid row" area to serve 26 homeless families that included a parent who had mental health problems. Interagency partners included the Department of Public Social Services (DPSS), the lead agency, the Department of Mental Health (DMH) and the Los Angeles Homeless Services Authority (LAHSA).
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- Phase Three (expansion): The two existing sites were expanded and an additional four sites were added in January of 2005. The skid row site has 100 participants and each other site has 50 participants for a total of 350 families. Each supervisorial district contains one site.

At the request of the Board of Supervisors, the Department of Mental Health contracted with the California Institute for Mental Health (CIMH) to conduct an evaluation of the outcomes of the 40 participants served in 2003-2004. The contract has been modified so that CIMH is also evaluating the expanded 350 participants' program.

This report contains:

- A description of the service model as it has evolved over three years, based on extensive interviews with project staff and related individuals, current through early May 2005.
- Outcomes for the 40 clients served in 2003-2004. Primary outcomes include engagement and retention in the program, housing, mental health status, status of the children, and employment-related activities. Secondary outcomes comprise material well-being, domestic violence, health, social support, learning disabilities, criminal justice involvement, and child care and transportation. Data are drawn from clinician ratings throughout the project, DMH and DPSS electronic records, and a research interview with participants conducted approximately one year after admission to the program.

The definition of "CalWORKs mental health clients"

The Homeless Families Pilot Project is intended to serve homeless CalWORKs-eligible parents who have mental health problems severe enough to constitute a barrier to finding housing and employment. However, these problems should not be so severe as to qualify for federal disability payments due to severe and persistent mental illness. Persons with a diagnosis of schizophrenia, for example, are likely to receive federal disability payments (SSI) and therefore not be on CalWORKs. Project eligibility is determined by the DPSS definition of homelessness, but other definitions may be applied by related agencies, such as administrators of the Section 8 housing vouchers.

Dimensions of the problem

CalWORKs participants with mental health problems are three times as likely as CalWORKs participants overall to become homeless.

CalWORKs participants who have self-declared mental health, substance abuse or domestic violence problems are more likely to be homeless than those without such problems. The Economic Roundtable has found that 8.1% of all CalWORKs participants with a welfare-to-work plan were homeless during a one-year period. However, 24.7% of those who self-declared they had a mental health need were homeless in a year.[1]

As many as 3,450 adult family members with mental health problems are CalWORKs participants and have been homeless during a year.

Staff profile of a client in temporary shelter:

"The client is a 26-year-old single female and domestic violence survivor living with her two children ages 7 and 2. Her fiancé was incarcerated due to the domestic violence and committed suicide in jail in 2003. She became homeless in March 2005 after being evicted due to non-payment of rent. Recently, she and her children were placed in a four-month residential facility. The client reports that despite the difficulty in transferring one of her children to a school in a different area, she is satisfied with the current living arrangements."

In March 2004, the California Institute for Mental Health conducted a random-sample survey of 310 of the CalWORKs mental health clients receiving services at that time. We asked, "During the past 12 months were you homeless on the street or in a shelter?" A total of 12.7% of the sampled participants reported being homeless. If this percentage is applied to the 8,242 CalWORKs-funded mental health clients seen in 2003-2004, we arrive at an estimate of 1,047 adults (parents) who were homeless on the street or in shelters during the year who *also* had a mental health problem that poses a barrier to economic self-reliance.[2]

However, CalWORKs clients can seek mental health treatment on their own, without it being in their welfare-to-work plan. In fact, in 2001 (the last date for which we have information) a higher percentage of clients are served in this "back door" mode than those who have the service in their welfare-to-work plan and are thus paid for through CalWORKs funds. A total of 13,970 CalWORKs participants in 2000-2001 received mental health services—either directly funded by CalWORKs or funded by other sources. Applying the 12.7% to that group, we arrived at a figure of 1,774.

We have been using the survey definition of homelessness—homeless on the street or in shelters—but the homeless indicator used by DPSS is less strict, permitting doubling up to count as homelessness, for example. As noted above, the Economic Roundtable found that 24.7% of those with a mental health indicator in their GAIN record also had a homeless indicator. Applying this figure to both the 8,242 and 13,970 figures discussed above as CalWORKs mental health clients (funded by DPSS or not), we arrived at a total potential number of parents eligible for homeless family services of between 2,036 and 3,450.

Thus, the number of parents who would be eligible within a year's time for a homeless families program that consisted only of those who had received DMH services varies from around 1,000 to 3,450 persons per year, depending on both the definition of homelessness and how the population of mental health service recipients is defined.

Among a random sample of CalWORKs mental health clients, those who have been homeless are younger, more functionally impaired, and less likely to achieve employment goals.

In the CIMH March 2003 staff survey of discharged CalWORKs mental health clients, a number of differences appeared between persons staff reported had been homeless and persons staff reported had not been homeless (those whom staff were uncertain about have been omitted).

- *Demographics*. Being homeless during the mental health treatment episode was significantly associated in the staff survey of 2003 with age (those homeless were younger) and with race (Asian Americans and Hispanics were less likely to be homeless)[3], but not with number of children.
- *Impairment*. Staff ratings of functioning in daily life upon admit[4] showed significantly more impairment for those persons whom staff reported had been homeless during the treatment (44.6 vs. 49.6 on a 100-point scale).
- *Service pattern*. Parents that staff reported had been homeless received mental health services for a shorter period of time at discharge than those who had not been homeless (an average of 7.7 vs. 10.5 months).
- *Outcomes*. Having been homeless was related to whether persons were employed at discharge.

According to staff, only 12.9% of clients who had been homeless were employed when they terminated services, vs. 27.5% of those who had not been homeless.

Homelessness among families is often temporary, especially when defined to include "doubling up."

The 2002 winter shelter survey of homeless family members found 86% were homeless for less than six months. In a fall 2004 survey of 373 adults applying for DPSS Homeless Assistance, 51% had been homeless for less than a month, 75% were homeless for less than two months, and 84% were homeless for less than six months—nearly identical to the winter shelter figure.[5]

Eligibility requirements for the Homeless Pilot Project exclude many who have similar needs.

The 1,000 to 3,400 persons potentially eligible for similar services discussed above reference CalWORKs participants—and eligibility for CalWORKs is a pilot project requirement. However, many homeless parents and children are not receiving or eligible for CalWORKs supportive services. LAHSA outreach workers in the Homeless Families Pilot Project reported that in both years they encountered substantial numbers of homeless families with mental health problems who are *not* eligible for the CalWORKs welfare-to-work program. These include undocumented persons and those with drug felony records, as well as those who are no longer eligible for welfare-to-work due to timing out. Also, if mental health problems were construed more broadly to include substance use disorders, far more families would be eligible—the *Homeless in LA Final Report*[6] revealed problems with alcohol and drugs to be the most commonly reported cause of homelessness among both individuals *and* families. Finally, since the rate of homelessness among CalWORKs recipients self-declaring domestic violence is higher than among persons self-declaring *either* mental health or substance abuse problems, an apparent need exists for collaborative services for domestic violence victims as well.

Adults and children in homeless Los Angeles families experience a wide range of behavioral and social difficulties.

Over the past 20 years, Los Angeles studies regarding this population and their children have been limited but document the following:

- Homeless women having children with them have high rates of stress, psychiatric disorders, domestic violence, and substance abuse; they are at high risk for sexual assault.[7]
- Children in homeless families are at high risk for missing school, delayed academic achievement, the experience of divorce, separation from one or both parents, and witnessing violence. Up to 25% have clinically significant mental health symptoms.[8]

The broader context

It is important not to "pathologize" the families in the Homeless Families Pilot Project, since the problems they face finding housing are for the most part systemic and not due to mental health difficulties. While mental health problems may make it more difficult to find or maintain stable housing, evidence shows that mental health symptoms in homeless mothers can be the *result* of the conditions of being homeless, particularly of living in shelters.[9]

The Homeless Families Pilot Project can be seen as the initial stages of building a safety net for a specific population numbering only a few thousand in Los Angeles. But the larger forces that produce families living in poverty on the edge of homelessness can not be ignored.[10] In the expansion to 350 participants, project staff report that the difficulties families encounter are for the most part due to a) lack of low-income housing stock, b) limited and restrictive emergency and transitional housing, c) difficulty finding funds for first and last month's rent and moving expenses, and d) the difficulty of pursuing employment or training while living in temporary situations.

In addition, a welfare reform experiment has demonstrated that wage supplements that increase income of welfare participants who find work to the equivalent of $17.50 per hour can do as much to reduce mental health problems as does treatment.[11] Similarly, a recent study demonstrated that a significant increase in family income in itself is associated with a large reduction in child behavioral symptoms.[12] So while planning specific services for homeless families in which a parent has mental health problems is important and will continue to be necessary, larger scale interventions to reduce poverty and promote affordable housing (such as expanded voucher programs for renters and tax incentives for housing developers) could obviate much of the current need for these specialized services.

PART 2: DESCRIPTION OF THE HOMELESS PILOT PROJECT SERVICE MODEL

The service model has changed over the three phases of the project, based on learning from experience but also due to the exigencies of funding. A summary of the basic principles of the model appears below.

- ❑ Provide services for one to two years, based on individual need;
- ❑ Provide services through a collaboration of the Department of Public Social Services, the Department of Mental Health, and the Los Angeles Homeless Services Authority;
- ❑ Co-locate staff to the extent possible;
- ❑ Provide therapeutic and case management services, as well as skills training groups (such as money management);
- ❑ Provide active assistance in locating both temporary and permanent housing;
- ❑ Make use of Section 8 housing vouchers and other rent subsidies to the extent possible; and
- ❑ Provide transportation.

Experience in Phase One and Phase Two has shown that programs need to be funded for at least a year, preferably two, in order to have a reasonable expectation of achieving project goals.

The model was originally designed to be a six-month intervention. But experience in Phase One and Phase Two suggested that this is an insufficient time frame within which to establish permanent housing (with or without Section 8 certificates). Additionally, most participants cannot become actively involved in training or seeking employment until they have some stability in their living situation. Staff have universally recommended a service duration of 12 months to two years, depending on individual circumstances.

The interagency collaboration involved in this project is a crucial element necessary for success.

Families who receive public assistance, who are homeless, and who also have mental health problems require a comprehensive approach if they are to succeed in finding and retaining permanent housing and employment. The initial board resolution required the interagency cooperation of the Los Angeles Homeless Services Authority (LAHSA), the Department of Public Social Services and the Department of Mental Health. LAHSA is responsible for identifying families in need, providing transportation, and finding temporary housing. Mental health services (including psychotherapy, case management, crisis assistance, and finding permanent housing) are provided by a county-operated or county-contracted agency. The lead agency is the Department of Public Social Services (DPSS), which provides CalWORKs eligibility and GAIN services and overall guidance for the program. Interagency meetings are held weekly to track participant progress and identify needs. A steering committee, composed of all agencies represented, meets monthly to recap progress and respond to agency issues.

CIMH interviews and meetings with agency staff from all three components of the project over the last two years have confirmed that this collaboration in the pilot project has been effective in making necessary decisions and in minimizing the disagreements and misperceptions that often result with interagency efforts.

Co-location of LAHSA and DPSS staff at the mental health sites has been very helpful, but practical problems continue to pose challenges.

Having all of the major project services and resources in one location near the clients to be served enables clients to access services more easily and increases the chance that they will follow through with the things they need to do to achieve success. In addition, the collaboration that occurs when staff are all in the same location results in the development of more effective policies and procedures, as well as more comprehensive and coordinated service plans for participants.

Eligibility workers have been assigned to each mental health site from the beginning of the project; GAIN workers were assigned beginning in Phase Two. LAHSA staff were readily available in Phase One, since both they and the mental health agency—the Downtown Mental Health Clinic—were located in the skid row area. The challenge was greater in having LAHSA staff co-located

during Phase Two given the distance from LAHSA's downtown location to the project site in the San Gabriel Valley.

Current challenges in Phase Three include a) inability of co-located DPSS workers to access the computerized data bases they need while co-located, and b) the time it takes each day for LAHSA staff to pick-up and return the vans they use from a downtown garage.

The model envisions mental health agencies providing clinical therapy, direct case management, and homeless assistance by staff dedicated to this program.

Therapeutic staff, case management staff and housing specialists are all part of the model. In Phase Two, the mental health provider in the San Gabriel Valley was able to provide both clinical therapy staff and case managers. In Phase Three, all sites have both capacities, although the designated funding for the project through DPSS does not permit billing therapy services, so they must be provided out of the general CalWORKs mental health supportive services funding. This arrangement works well for some providers but not for others.

A first objective of the programs is to establish safe temporary housing.

The Phase One pilot in skid row area utilized emergency shelters located in the downtown area. Access to this resource was facilitated by the location of LAHSA in the area and the location was convenient for clients who were homeless in the downtown area.

Difficulties arose regarding reliance on emergency shelters for immediate stabilization of housing in Phase Two in San Gabriel, which did not have any emergency shelters located in the area. Families were reluctant to be housed in a shelter outside the area, since it could mean changing their children's school and might jeopardize their chances for obtaining permanent housing in the San Gabriel Valley, where they had other established supports.

These complications with the use of emergency shelters became even more apparent during the Phase Three expansion. In some instances shelters had waiting lists to get in. In other cases, the families were not eligible for the shelters because of a lack of family friendly policies. (Examples include: not accepting families with sons over 12 years old, not accepting infants, not accepting large families, or requiring parents to be married.)

The challenges around the need for immediate stabilization of housing remains a problem and may well depend on the circumstances within each geographic region. Having LAHSA as a housing partner enhances the chances of making the shelter system more responsive to the needs of these families, but over time other alternatives to the use of shelters (e.g. hotel vouchers, or placing families directly in transitional housing) may be found to be more beneficial.

Mental health staff are responsible for finding permanent housing.

While LAHSA finds emergency shelter and transitional housing (for up to two years), finding permanent housing is the responsibility of the case managers and housing specialists employed by the participating mental health clinics. This is a new role for many mental health agencies, but they have taken it on with enthusiasm and skill.

Section 8 housing vouchers and other forms of housing assistance are critical to the model.

A major improvement in the model occurred in Phase Two in which all 40 families were guaranteed a Section 8 voucher if they completed the application process and were eligible. As will be noted in the Outcomes Section (see below), having a Section 8 voucher has been a necessary but not sufficient condition for Phase Two clients to obtain permanent rental housing.

The shortage of vouchers overall[13] has led to having only 50 vouchers available for the 350 clients in the pilot program's Phase Three expansion. The design of the Phase Three evaluation includes a test of the importance of the Section 8 vouchers. Clients assigned a Section 8 voucher will be compared with comparable clients on the Section 8 waiting list. This will provide an extremely valuable assessment of whether the model is viable without Section 8 vouchers.

Assistance from staff is needed even with the Section 8 vouchers. The application process is time-consuming and detailed and may require clients to pay for obtaining birth certificates or other documentation. Program staff have spent considerable time in assisting clients to obtain all the necessary documentation and in facilitating all the pertinent

agencies to act expeditiously on the paperwork.

With the lack of Section 8 vouchers for most clients in Phase Three, the collaborating partners have sought out additional resources for Phase Three programs. DPSS has added 14 days of Temporary Homeless Assistance and Rental Subsidy Assistance of up to $250 for four consecutive months for eligible families who have found permanent non-subsidized housing and gone through the STEP vocational training program. DPSS also has identified specialized workers to respond to issues relating to move-in costs, permanent housing, relocation and moving assistance. Clinical staff at each site are providing money management and other types of group education to assist clients in gaining the skills necessary for long-term tenancy. And DMH has identified a Home Options Made Easy (HOME) team that dedicates its time to networking with landlords and finding permanent housing.

Efforts have been made to respond to children's needs and other needs of the parents, but this is through referral rather than direct provision of services.

Mental health staff recognize the added risks to the children in these families and attempt to identify particular problems experienced by the children in the families they serve. But no provision is in place for systematically screening or assessing children. The programs have established referral arrangements with mental health agencies (or sometimes other therapists within the same agency) that specialize in children's services.

A large percentage of the clients have had histories of witnessing or being subjected to violence in their lives, and many have experienced recent or current domestic abuse. A smaller percentage of the clients have active substance abuse issues. While criminal justice involvement is infrequent, many clients have other legal issues related to their family situations or other problems. Having expertise to respond to multiple other issues within the scope of the programs would be ideal, but currently these are being referred to other organizations.

The provision of transportation is an explicit component of the model.

Funds for transportation, vouchers and/or the direct provision of transportation is a necessary part of these projects. At times the project staff have had difficulty getting other parts of the system to accept their responsibilities, e.g. schools are responsible for transporting homeless children to school.

Open issues

While the project has been remarkably flexible in adapting the model based on actual experience, open questions remain. Given the complexity of the personal and system issues that arise in trying to assist these families, the model continues to evolve. Here is a set of issues that policy makers should consider, particularly if the program is to be further expanded.

- How should clients be selected for the programs? Given the scarcity of Section 8 vouchers and the high cost of the intervention, how should the target population be defined? Should preference be given to the clients who face the most barriers (e.g. longer periods of homelessness, or more serious mental health issues)?
- What are the best alternatives for the initial stabilization of housing? Can shelters be made more "family friendly"? What other options might be used? How can families be supported in maintaining their ties to the region from which they come?
- How can the needs of children best be addressed? Is it feasible to incorporate child specialists within the service team, or will this make the model too expensive?
- Can clients be moved more quickly into more intensive education, training, work-related activities to enhance their ability to obtain employment? Would the addition of special vocational rehabilitation specialists facilitate this process?
- With the longer time frames, can the programs vary the intensity of the service over time so that the average cost of the program per client is reduced?
- How essential to the project model is the presence of the Section 8 vouchers?

The CIMH evaluation of the Phase Three programs will provide additional insight into some of these open issues.

PART 3: PROJECT PARTICIPANTS AND THE OUTCOMES OF THEIR SERVICES[14]

A. CLIENT CHARACTERISTICS

The homeless families represent a wide range of family constellations and life circumstances.

Three of the 40 parents enrolled as mental health clients are male; 37 are female. Thirty seven have English as a primary language, three are monolingual Spanish. The largest racial/ethnic group is Hispanic (42%)[15] followed by African American (38%), and Caucasian (15%). A majority are over 35 years of age. Half of the families have only one child, 40% have two or three, and 10% have four or more, including a family with eight and a family with nine children. Seventeen percent of the interviewees were married (and lived with their spouse), while 53% had never been married.[16]

Parents participating in the project are more educated than are CalWORKs participants overall: three-fourths of the parents had finished high school, compared to 49% of Los Angeles CalWORKs participants who are not homeless.[17]

Most parents received welfare prior to entering the pilot program.

Of the 40 participants, DPSS records show 33 had received CalWORKs at some point prior to enrolling in the project. Four had initially received CalWORKs between 1990 and 1995; six initiated CalWORKs between 1996 and 2000, four started receiving CalWORKs in 2001, 10 in 2002, and three in 2003 (but prior to enrollment in the pilot).

Two measures indicate Homeless Pilot Project parents have psychiatric impairments with roughly the same degree of severity as other CalWORKs mental health supportive services clients.

In order to judge the severity of the mental health problems of pilot project participants, we compared them to a random sample of CalWORKs supportive service mental health clients.[18]

- A staff rating of Global Assessment of Functioning (GAF) at admission showed the pilot project participants to be slightly less impaired than the larger sample of CalWORKs mental health clients.[19] Note, though, that a wide range of functioning levels is shown in both samples.
- The diagnostic profile of the two groups was similar. For example, the two groups have nearly identical percentages of depressive disorders: 58% for pilot project parents and 59% for the larger population. One difference, however, is the somewhat larger percentage (12% vs. 7%) of pilot project parents with serious mental illness (bipolar or other psychotic disorder).
- Clinical staff at both the Downtown Mental Health Clinic and PROTOTYPES clinic have worked with CalWORKs mental health clients for several years. At both sites they affirmed that the mental health problems of pilot project participants seem consistent with those of CalWORKs mental health clients in general.

Taken together, the available information indicates that the mental health problems of pilot project parents are not more severe than of other CalWORKs mental health participants.

B. PRIMARY OUTCOMES

Program engagement and retention

Pilot project parents were slightly more engaged in therapy than a random sample of CalWORKs mental health clients, but less so than is desirable.

The first and critical outcome is retention and participation in the program. According to the clinicians' final summary for 38 clients, six terminated early. (Three of these moved away from the service site.)

In addition, staff report that only 51% of the participants had "good" or "very good" participation in treatment. In some cases, obvious reasons accounted for the lack of participation (such as working full time, receiving cancer treatments, or having moved a considerable distance away), but some simply did not use the therapeutic resources available to them. Although disappointing, this pattern is actually somewhat better than for a random sample of CalWORKs mental health clients overall.[20] Figure 1 shows the pattern for both groups.

Figure 1: Participation in mental health therapy: homeless pilot project parents vs. random sample of all CalWORKs mental health clients

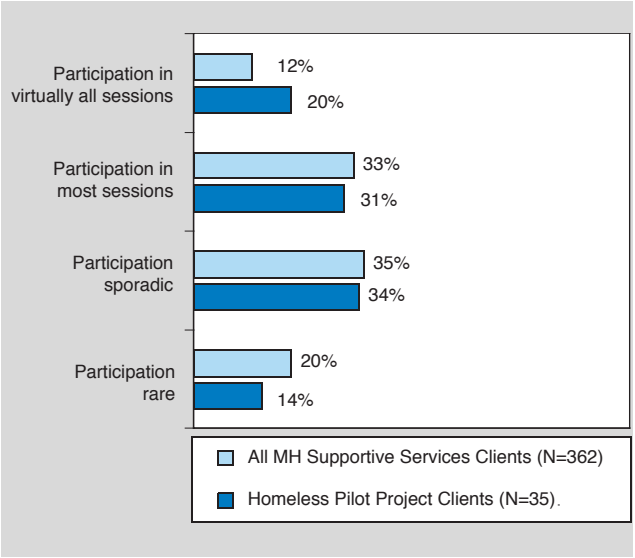
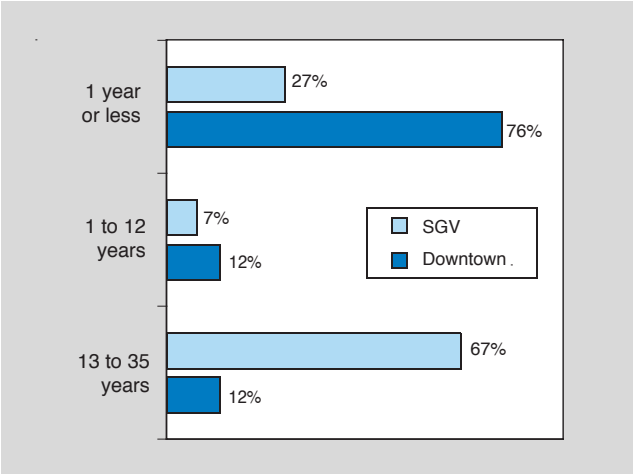


Figure 2: Time participants had lived in downtown or San Gabriel Valley (N=32)



Housing

Families varied widely in their previous housing stability; San Gabriel residents had been much more stable.

The number of moves occurring during the study period[21] that families reported in follow-up interviews varied from none (four families) to 20 (one family). Downtown and San Gabriel Valley families were very different in their relationship to the region in which they were served. At admission, downtown participants had been in that area a mean of 3.2 years (median of six months) vs. the 14.4 years (median of 16 years) San Gabriel Valley participants reported living in that area.[22] Figure 2 shows this graphically. Thus, it is very important to help most of the San Gabriel Valley residents remain in the area.

Most families were homeless due to loss of job or income.

At the interview conducted by clinicians two months into the program, clients were asked why they were homeless when they entered the program. Many parents reported eviction or rent increases (13), loss of job or income (4), conflict with a partner or relative (6), or physical health problems (4). Only two persons mentioned a mental health problem as contributing to homelessness.

As of May 15, 2005, 35% of the 40 participants were living in rented apartments or houses, 20% were in temporary shelters, and 20% were living with friends or family.

Homeless pilot project staff kept records of the housing situation for all 40 clients. Staff distinguish time-limited shelters from other housing that is not time limited—referred to as "permanent" housing but meaning in practice rental housing.

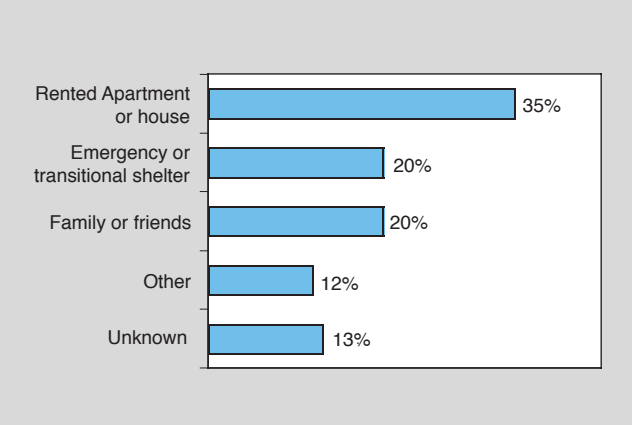
As seen in Figure 3, rental housing supported by Section 8 vouchers was found by 14 of the 40 participants (35%). The other major categories were shelters (eight persons or 20%) and friends or

Parents in two families describe how they became homeless:

"Where I was residing the heirs sold the property and I had to move after the property was sold. I had been there for 14 years."

"My work hours got cut, I wasn't getting child support for my son, so I couldn't pay the rent any more."

Figure 3: Housing of 40 Year Two Homeless Pilot Project participants as of May 1, 2005



family (also eight persons or 20%). The living situation of five persons (13%) was unknown. In addition, one person rented a room, two were in nursing homes, and one was in a sober living home after completing drug treatment. Note that in May 2005 none of the participants were living in a rented apartment or house unless they were using a Section 8 voucher.

San Gabriel Valley participants were more likely to find rental housing.

Only four persons of the 20 from the downtown area were in rented apartments or houses. The detailed site-by-site report of housing status as of May 1, 2005 is shown in Table 1.[23]

Table 1: Housing status as of May 1, 2005

Type of housing	SGV N	SGV Percent	Downtown N	Downtown Percent
Emergency shelter	1	5%	2	10%
Transitional shelter	2	10%	3	15%
Rented room	0	0%	1	5%
Rented house or apart	0	0%	0	0%
Rented using Section 8	10	50%	4	20%
With parents	0	0%	2	10%
With other relatives	2	10%	4	20%
With friends	0	0%	1	5%
Nursing home	1	5%	1	5%
Sober living home	0	0%	1	5%
Unknown	4	20%	1	5%
TOTAL	20	100%	20	100%

Obtaining a Section 8 housing voucher is an important and perhaps critical component of success in achieving permanent housing. Sixty-five percent of the pilot participants received a Section 8 voucher.

Section 8 vouchers (which provide federal rent supplements sufficient to keep the renters' payment at 30% of their income) were considered a critical element of the Year Two Homeless Families Pilot Project. A total of 26 or 65% of the 40 participants received the vouchers. Table 2 shows the December 31 status of all 40 participants with respect to Section 8 vouchers.

Table 2: Section 8 voucher application status

Status	N	%
Voucher issued	26	65%
Case closed in Homeless Project	4	10%
Denied Section 8	4	10%
Ineligible	2	5%
Failed criminal background check	2	5%
Section 8 applied for prior to project	2	5%
TOTAL	40	100%

Once a Section 8 housing voucher is obtained, a rental must be found and approved within 90 days. A number of problems may make this difficult, including a lack of housing stock, landlords' reluctance to accept vouchers, and delays in inspection of the rental by housing authorities. Although 26 families were granted a voucher, only 14 were in vouchered housing as of May 1, 2005.[24]

A majority of parents in follow-up interviews were satisfied with their housing situation.

In follow-up research interviews with 28 parents, 13 were very satisfied and eight were somewhat satisfied with their housing situation. Not surprisingly those in rented housing were very satisfied while those living with relatives and in emergency shelter were more likely to be dissatisfied.

Mother of nine children:

"Finding a place has been hard because people don't want to rent to so many kids."

Mental health status

Mental health status showed improvement, but only some results were statistically significant.[25]

Client-reported mental health status on the SF-12 scale increased to a statistically significant degree over time. We compared the scores of clients on the scale at two months after admission with scores at the follow-up research interview. The mean score increased (higher scores are better) from 35.6 to 41.1, a statistically significant change.[26]

Staff-rated Global Assessment of Functioning scores improved little between ratings made at the second month and ratings made at the tenth month (54.5 to 56.6, not a statistically significant change). Ratings on the 17-item Multnomah Community Abilities Scale show improvements from two months to 10 months; however, this change is not statistically significant.

Nonetheless, clinical staff were optimistic that many participants would be successful in overcoming their mental health issues. Staff reported 77% of parents had made at least "some positive change" on their primary mental health problem. Staff also were asked, "How successful do you think the client will be in overcoming mental health issues?" For 13 clients, staff reported a positive prognosis. Staff indicated 12 clients would be successful only if they continued their mental health therapy (or in one case substance abuse treatment). Doubtful or negative prognoses were offered for 10 clients because of a pattern of non-participation in treatment.

Disability days due to mental health symptoms also declined, but not to a statistically significant degree.

We compared client-reported mental health-related days of disability[27] at two months into the program with days of disability at the time of the research interview. The overall means were 8.7 at two months vs. 6.5 at the time of the research interview. (For the 26 persons taking part in both interviews no statistically significant change occurred over time.)

Staff were asked how much positive change clients made in the ability to carry out the tasks of daily life. At the final summary "some positive change" in functioning was reported for 78%.

Mental health status and other outcomes

Among participants in the follow-up interviews, having fewer psychiatric symptoms was associated with greater housing stability.

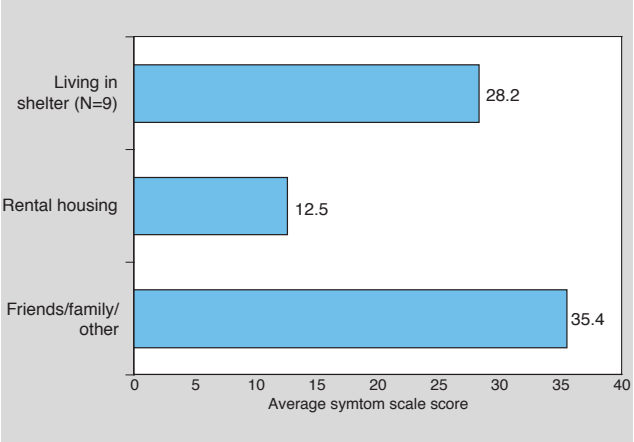
Scores on an extensive self-report symptom scale (the BASIS-32) were statistically significantly better if participants lived in their own rental housing.[28] See figure 4.

In addition, a low number of disability days

Staff on how the program has helped a parent:

"Stabilization has allowed this client to focus on employment and educational goals. Prior to permanent housing she began researching training programs and requirements. She has set a specific date for when to begin working toward educational/employment goals."

Figure 4: Symptom scale scores at follow-up, by type of residence (lower scores indicate fewer symptoms)



was correlated with having one's own rented housing. These associations suggest two alternative hypotheses: a) those who achieve permanent housing had fewer symptoms to begin with; *or* b) achieving permanent housing reduces symptoms.

We used the SF-12 mental health scale to test these two hypotheses.[29]

- At two months after admission, the SF-12 mental health scores for persons who would eventually end up in permanent housing were no different from scores of those who did not obtain permanent housing. That is, the lower number of symptoms at follow-up of those in permanent housing are *not* just a reflection of fewer symptoms to begin with.[30]
- Positive *change* on SF-12 mental health status was associated with having a place of one's own at follow up.[31] Thus, the data are consistent with the hypothesis that positive change in mental health status *results* from having permanent housing.
- However, the finding that positive change in mental health status is associated with having permanent housing is also consistent with the possibility that the causal sequence starts with responding to treatment which then leads to better mental health status. That, in turn, leads to obtaining permanent housing.

Without a series of measurements over time we are not able to say definitively which factor (having housing vs. making rapid progress in treatment) better explains the association of permanent housing with positive mental health status.

Child well-being and parenting

At intake, staff rated parents' ability to meet the needs of their children as "good" or "very good" in a majority of cases; these ratings improved substantially for many clients during the project.

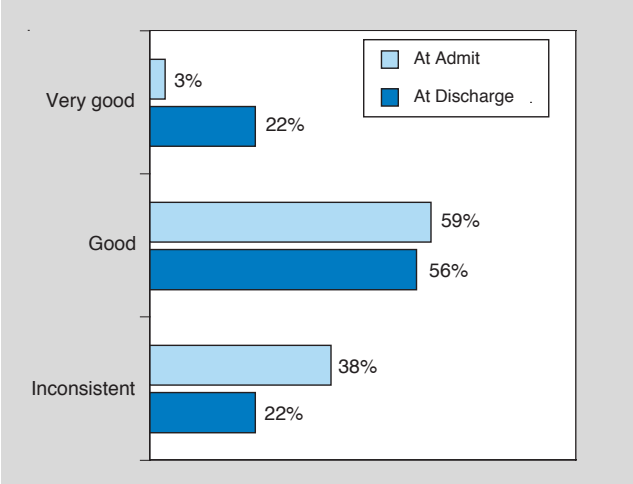
Case managers rated a parent's ability to meet children's needs as "good" or "very good" at intake for 21 out of 36 families (58%). None of the parents were rated as "deficient" or "unsafe." Final assessment information from staff on the same measure was available for 34 of the families. As seen in Figure 5, "good" or "very good" care increased from 58% to 71% during the study period, a statistically significant improvement.[32]

The most common reasons for improvement mentioned by staff were increased housing stability and decreased stress.

For many parents, child support was not paid; and for a minority of parents, child custody became an issue.

At the follow-up research interview, 27 families

Figure 5: Change in staff-rated parenting capacities from admission to discharge



had a child living with them who had one parent living elsewhere; only six of these received financial contributions from the absent parent although eight were covered by a child support order; only two parents reported receiving full payments.

For various reasons, a number of the family situations were unstable. Three parents had children restored to them by child welfare services during the course of the project,[33] and one family

was in the process of "reunification."

Children had health, dental, and mental health needs that were not always met.

We asked follow-up interviewees, "How often in the past 12 months did your children get the medical care they need?" While 70% responded that needed care was always obtained, in several families obtaining care was quite problematic. The percentage saying "all of the time" did not improve between two months into the program and the follow-up interview.

Dental care was even more problematic, as 37% of the families reported at follow-up that their children received the care they needed "very little of the time." Figure 6 shows the percentages in each category receiving medical and dental care.

Two parents describing why getting medical services is difficult:

"The county assigned me to an HMO, it's a county facility. [You have to go] at 7:00 am whenever you need to be seen, but I need to take kids to school then."

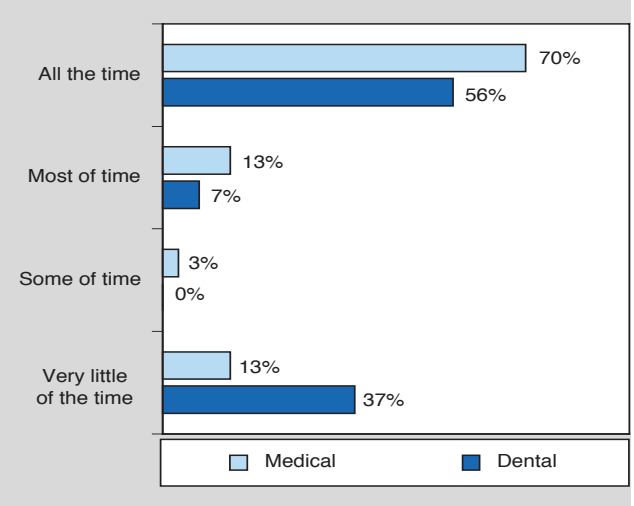
"Medi-Cal was a problem because I was on an HMO. The HMO didn't cover if you are homeless—you have to live in the area before they would treat you."

Failure to get medical or dental care was not related to child care, but was related to transportation (it was the reason most frequently given for both medical and dental). Problems with insurance (including finding a dentist who would take Medi-Cal), lack of money, and getting off work all contributed to some degree.

A number of children had serious health and mental health problems, some of which are likely to reduce the ability of their parents to find employment.

While the average rating on two standardized child behavior scales was in the "higher functioning" range, some children had behavioral or physical difficulties. In both the interview at two months *and* in the follow-up research interviews, six parents said that a child in the household had an on-going physical, mental, or emotional problem or disability that limits the parent's activities (e.g., by requiring special care at home or preventing the parent from undertaking a job).

Figure 6: Children's receipt of medical and dental care over past year, reported by parents (N=30)



In their final assessment of participants, clinicians reported parents had told them about a number of problems concerning their children. One had on-going health problems, two had learning problems or school difficulties, five had symptoms of depression, and three had anger, defiance or oppositional behavior. Two teenagers were hospitalized during the project due to suicide risk.

Project staff did not systematically assess and serve children in the families, but referrals for mental health services were common.

Of the 36 families reported on in staff final assessments, none of the children had been seen for an assessment or therapy by project therapists. Staff did, however, refer children in 14 families for specialized services. In 12 cases the referrals were followed-up by parents, at least initially. In research interviews with parents, 11 said a child had needed mental health care in the prior year, and eight said it had been provided.

Children had relatively little absence from school, and changing schools decreased during the study period.

The 30 participants in follow-up interviews had a total of 53 children over age 5, and 51 were reported by the parent to attend school regularly.[34] The percentage of children who had changed schools two or more times in the previous year decreased from 80% at an initial interview to 32% in the follow-up research interview.

Employment, training and school

DPSS and client follow-up data shows that 18 project participants worked during the study period.

Of the 37 persons with a DPSS GAIN record, 11 (30%) had a record of employment during the period from October 1, 2003 to September 30, 2004. One person left one job to take a better one, otherwise those employed had only one job. Of the 27 participants in follow-up interviews (about three months after the DPSS data ended), 13 (48%) reported working in the prior 12 months, and seven were working at the time of the interview. However, because the DPSS and interview data pertained to different persons (and time periods), the total number having worked during the study period (according to either one or the other source) was 18 persons, or 45% of all participants.

"Family counseling should be expanded and directed toward families.... Treating the family system should be the primary focus of any intervention aimed at children."

From: Cousineau, M. R., Nocella, K., Cross, T. A., & Jefferson, M.-E. (2003). Neglect on the Streets: The Health and Mental Health Status & Access to Care for the Homeless Adults & Children in Central Los Angeles.

Follow-up interview participants who worked in the past year reported wages of no more than $10 per hour, and a majority earned less than $7.50 per hour. Only three persons received any kind of benefit (sick days, vacation, health insurance or retirement).

About 40% of participants took part in employment-related activities.

According to DPSS records, 14 persons (38%) took part in community service, work experience, remedial education, Self Initiated [educational] Program (SIP), or vocational training during the period from October 1, 2003 to September 30, 2004.

Out of 29 participants in follow-up interviews, 13 (45%) said they had participated in some form of schooling or training within the past year. Neither the time frame nor the categories in the research interview coincide exactly with the GAIN data, but the conclusions are similar: 38% of GAIN records and 45% of participants in follow-up interviews show some vocational training or schooling activity.

Project staff felt that capacity to work had improved for 18 clients.

About two fifths of the 36 clients for whom we had final assessment information were judged by case managers to have good or very good capacity to work at the time of the last or most recent visit. Project staff noted that three clients had worked throughout the project, and staff felt that capacity had improved for 18 of the other 33 clients.

However, project staff also recorded some setbacks experienced by clients. For five clients, mental health symptoms still reduced capacity to work. Three of these clients did not engage in treatment. One had an increase in psychotic symptoms, and a staff member reported, "depression and anxiety have increased due to denial of Section 8 voucher; client has been less stable and therefore I believe client's capacity to work has decreased." One parent's capacity was reduced by having to undergo treatment for cancer and another's by having a new infant. In all, eight were noted as having negative change in capacity to work, and four others showed no change.

Overall, in their final assessments project staff determined that eventual success in employment was likely for about three-fourths of the clients. For 15 clients, the prognosis was unambiguous; for

Staff describe a client who is getting permanent housing:

"The client is a 35-year-old survivor of domestic violence with two children, currently seeking services for symptoms of panic attack. She reported becoming homeless after she decided to move to Los Angeles to enroll her children in a school program for the gifted. She moved under the impression that her friends in Los Angeles would assist her until she obtained her own apartment, but those plans fell through. She was referred to a shelter program and has just finished her last interview for their apartment program. She will be placed in one of their apartments, which can be paid for by her Section 8 voucher, which she received prior to moving to Los Angeles. She has decided to go back to school and is currently enrolled as a Child Development and Honors English major."

another 12 the prognosis was positive but conditional on getting stable housing or continuing mental health treatment.

C. SECONDARY OUTCOMES

Material well-being

In follow-up interviews, 30% of families reported hunger, and fewer than half the children were perceived to be safe in their neighborhoods all the time.

Participants in follow-up interviews were asked whether there was a time when they or their children were hungry because of inability to afford food. Of 29 families, the parents in nine families (31%) indicated they or their children had been hungry in the past 60 days due to inability to afford food. Seven of these parents said the family had been hungry for two to three days, and two families reported they were hungry for four to 10 days of the prior 60 days.

Participants in follow-up interviews were asked how often they feel safe in their neighborhood, taking into account things like gangs, drug dealing, street fights, and crime. They also were asked how often their children are safe from physical harm in the neighborhood. Less than a third of parents (31%) and only a half of children (52%) were perceived to be safe all the time—certainly not a situation that any parent would find satisfactory.

Parent health and health care

Almost a third of the participants in follow-up interviews had health conditions that might affect the capacity to work.

At follow-up interviews, we used the standardized SF-12 scale to measure limitations of functioning due to health (either mental or physical): 31% of the 26 clients had a score so low on the health subscale that it indicated a substantial probability of being unable to work.[35]

Domestic abuse and traumatic violence

A history of traumatic violence was reported for over half of the participants.

Eighteen of the 30 participants (60%) in follow-up interviews had experienced some sort of traumatic violence in their lifetime. The highest percentage (47% of the 30) had witnessed violence. However, 40% had experienced emotional abuse from a partner, and 37% had experienced physical abuse; a third had experienced physical abuse as a child, and a quarter had experienced sexual abuse as a child; 10 percent had experienced sexual abuse as an adult.

Five of the 18 participants who had experienced these traumatic events had told a physician or counselor about post-traumatic symptoms. Five had taken medications for the post-traumatic symptoms caused by these events; six said the post-traumatic symptoms had interfered with their activities in the past year; and one said she had used alcohol or drugs in response to these symptoms.

About a third of the participants in follow-up interviews reported some adult domestic abuse in the prior 12 months; serious physical abuse was reported by six of 30.

A total of 12 of 30 participants in follow-up interviews reported at least one abusive act in the past year. When the 12 respondents were asked how serious the abuse was, five said, "Not very serious," five said, "Moderately serious," and two said, "Very serious." Victims reported that the abuse either stayed the same (6 persons) or got less serious (5) over the previous year. Two victims reported they were currently afraid of a past or present partner. Three of the persons were still in a relationship with the abuser while eight were no longer in the relationship.

Participants in follow-up interviews were also asked about whether they had sought help for the domestic abuse; nine of the 12 had. Parents who reported abuse were asked if they had been told by a welfare staff person about the domestic abuse option: 76% reported they had. Five parents said that a reason they had received cash aid from welfare in the previous 12 months was because they "were trying to get away from an abusive situation." Two parents reported that they had, in the past two years, chosen not to apply for child support (or not to complain if it was not received) due to fear of partner abuse. Five parents said they had applied for a domestic violence waiver due to partner abuse. Three reported receiving a referral for domestic violence services from a welfare worker.

In their final assessments of client status, clinical staff reported that two women had to take out a restraining order against ex-partners; additionally, police were called to intervene in a conflict between a client and her husband. Staff reported the degree of change in domestic violence for 12 clients: three had strong positive change, five had "some" positive change in their situation; and four had no change. Three persons received a "domestic violence waiver" regarding CalWORKs requirements.

Problems with alcohol or other drugs

Alcohol and drug problems affected a minority of participants, and several made positive changes.

Participants in follow-up interviews were asked a set of alcohol- and drug-screening questions. None had ever lost a job or had job problems due to alcohol, marijuana or other drug use; and although seven had to take drug tests in the past year, they all passed.

One participant characterized herself as currently substance dependent, three other participants have had problems with marijuana in the past six months, and six are recovering alcoholics and/or drug addicts. In addition, the partners of two women are dependent on alcohol and/or drugs, and five other partners are recovering alcoholics and/or drug addicts.

Project staff reported making three referrals for substance abuse treatment during the course of the study period. Two follow-up interviewees reported getting substance abuse treatment within the past six months—one through a counselor at a shelter and one at a residential program. In each case, methamphetamine was the primary drug. Each entered treatment voluntarily (as opposed to being

Staff describe a client who found full-time work while looking for housing:

"The client is a 47-year-old separated survivor of domestic violence with four adult children and one minor child who lives with her. Her 17-year-old son was shot when he was 14; he is angry and has been physically abusive towards her. She became homeless in August 2004 when she left her rented property due to abusive male neighbors and because the neighborhood was dangerous. The client was employed at the time that she left her home and began living in various hotels and with family members. She eventually lost her job due to missing multiple days at work to deal with her son's school, court and mental health issues. She now has obtained full-time employment, is participating in an academic program, and is volunteering at her church. She and her son are temporarily living with one of her adult daughters."

mandated to treatment by a court or other agency). Both said they had successfully completed treatment.

In their final assessment of change for the seven clients they regarded as having substance abuse issues, clinicians rated two as having strong positive change, two had some positive change, one did not change, and two had negative change during the study period.

Criminal justice history

Criminal justice problems affected a small number of participants.

A criminal justice history can be of consequence for homeless families in several ways. It can, as it did for two pilot project parents, disqualify applicants from receiving a Section 8 voucher. If it is a felony drug conviction, it can disqualify parents from receiving Medi-Cal. It can contribute to having children removed from the home by Child Protective Services. Finally, many job application forms ask about criminal justice history.

Of 28 respondents, seven reported having been arrested and charged with a crime at some time in their lives. None had been incarcerated in the previous 12 months, however, and in the two years prior to entering the pilot project, only two persons had been in jail—for periods of 42 days or less.

During the study period, one person was arrested and sentenced to residential treatment on drug charges. A second person was discovered to have an outstanding bench warrant when application was made for a Section 8 voucher. She was sentenced to probation and ordered to take a parenting class.

Learning disabilities

About one third of the participants in follow-up interviews are likely to have learning disabilities.

DPSS does not automatically screen for learning disabilities, so the follow-up research interview contained the State of Washington learning disability screening tool—which has an overall 74% accuracy rate for identifying learning disabilities. Of the 29 persons answering these questions, nine (31%) screened positive, including six who reported having been in a special program or given extra help in school.

Respondents who reported being disabled for five or more days of the previous 30 due to mental health symptoms were significantly more likely to have high learning disability scores as were those who had less than four of the nine work skills which we inquired about in the research interview.[36]

Child care and transportation

For a minority of clients, child care access, costs or quality cause difficulties in working or going to training, or school.

Only 21 of the 30 clients who participated in the follow-up research interview said that they needed child care for work, training or school. For a minority of respondents, obtaining child care is an issue. While only four of the 21 said that child care was very difficult to obtain, another five said it is "somewhat difficult" to obtain. Three parents were paying for child care ($30, $50 and $100 a week, respectively). And five of the 21 parents had to travel a half hour or more in order to take a child to child care.

Several parents said child care problems had caused interference with work, school or training. The most common type of interference (30% of all responses and 100% of the seven cases) was causing the parent to be late or absent. However, four parents said they had not participated in work, training or school due to child care problems, three said they had turned down a job, and two said they had to quit or had been fired. All in all, four of seven who reported child care problems had turned down, or lost, an opportunity to work, train or go to school due to problems with child care.

Lack of transportation caused problems for a substantial minority.

Pilot project participants had access to transportation for project activities through LAHSA. Of the 30 participants in follow-up interviews, 21 said they received some assistance with transportation to work, school or training (such as bus passes). However, we were told by staff that transportation to school was a problem for some of the families (especially if they were in temporary housing away from the child's usual school). Twelve of the 30 participants in follow-up interviews reported that during the prior 12 months, lack of transportation interfered with work, school or training. In addi-

Staff describe a case in which there were two transportation problems:

"One mother and her son who were homeless in Tarzana were placed in a shelter in South Central. The boy was picked up at a nearby school and transported by the Tarzana school district to his existing school. The mother and boy were moved to another shelter in San Pedro, where they had to get up at 4:00 am each day to drive to the South Central school where the Tarzana bus picked the boy up. When the mother's car broke down, she used savings to fix it so her son could continue in his school. However, the shelter required residents to save their money, so using the savings for auto repair resulted in being evicted from the shelter."

tion, only 13 of the parents had a California driver's license and only 10 had access to a car if needed for child care, training, school or work. (Of those reporting their mode of transportation when they were working, five drove their own car, four took a bus, and one walked to work.)

Social support

A majority of participants in follow-up interviews reported having support for a variety of needs.

Approximately 80% of the participants in follow-up interviews felt they had someone to turn to for emotional support or help with a personal problem. However, a majority said they would be unlikely to have anyone willing to provide them with several hundred dollars if it was needed (for car repair, say) and 37% said they would not have someone who could help take care of them if they were sick in bed for several weeks. Family were most likely to provide *little* support while staff in the mental health agency were perceived by a majority as providing *a lot* of support.

D. CONCLUSION

Pilot project direct service staff—whether they work for mental health clinics, the Los Angeles Homeless Services Authority, or for the Department of Public Social Services—are dedicated and skillful. Over time they have gotten better and better at figuring out ways to help homeless parents with mental health problems. They are actively supported by capable administrative staff at all three agencies.

We hope that this report contains enough detail to show the reader the many difficulties homeless parents in the pilot project face but also something of the resourcefulness they have brought to the task. Staff can assist, but parents must take action. Parents in the pilot project have confronted, and are overcoming, substance abuse, domestic violence, inadequate social support, limited incomes and other material resources, and homelessness itself.

The pilot program's coordinated approach to services is resource-intensive but pays off in the experience parents have of support and helpfulness as well as in the outcomes presented here.

NOTES

[1] Personal communication from Dan Flaming, Economic Roundtable. The definition of homelessness used is the "indicator" or "flag" entered into the DPSS GAIN data system when homelessness is reported.

[2] The 95% confidence interval—a range that takes account of possible sampling error—for the 1,047 figure is 732 to 1,356.

[3] In the expanded Phase Three project a majority of the participants are Hispanic, thus differing in this regard from the overall population of mental health supportive services clients who were homeless during the year.

[4] Global Assessment of Functioning Scale, or GAF.

[5] Flaming, D., Burns, P., & Haydamack, B. (September 2004). *Homeless in LA: Final Research Report.* Los Angeles: Economic Roundtable 315 West Ninth Street, Suite 1209, Los Angeles, California 90015.
Bono and colleagues., op cit. These figures are confirmed by the CIMH study of a random sample of CalWORKs participants in Kern and Stanislaus counties: 60% of those who were homeless in the prior year were homeless for a month or less and this time did not differ by whether the parent had mental health needs (unpublished data).

[6] Flaming, D., Burns, P., & Haydamack, B., op cit.

[7] Dennison, B., Mendizabal, A., & White, P. (2004). *Many Struggles, Few Options: Findings and Recommendations From the 2004 Downtown Women's Needs Assessment.* Los Angeles: Downtown Women's Action Coalition.
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[10] In California, the percentage of children in poverty is increasing, with rates of 34% for Hispanic children and 24% for African American children. Palmer, J., Song, Y., & Lu, H.-H. (2002). *The Changing Face of Child Poverty in California.* New York City: National Center for Children in Poverty. http://www.nccp.org/pub_cpc02.html. Median income for renters has been decreasing and rental prices have been increasing leaving persons on welfare or working in low-wage jobs in progressively more difficult circumstances.. City of Los Angeles Housing Department, Building Healthy Communities 101, available at: http://www.lacity.org/lahd/curriculum/index.html

"For the rest of 2005, rents [in Los Angeles County] should increase almost 4% to an average of approximately $1,200 for a one-bedroom, $1,500 for a two-bedroom and $1,700 for a three-bedroom unit." (April 2005). Source: http://www.usc.edu/schools/sppd/lusk/press/item.php?id=548

[11] Cremieux, P., Greenberg, P., Kessler, R., Merrigan, P., & Audenrode, M. V. (2004). *Employment, Earnings Supplements, and Mental Health: A Controlled Experiment.* Ottawa: Social Research and Demonstration Corporation.

[12] Costello, E. J., Compton, S. N., Keeler, G., & Angold, A. (2003). Relationships between poverty and psychopathology: a natural experiment. *JAMA*, 290, 223-2029.

[13] There have been long waiting lists for Section 8 vouchers for some time. Recent changes in the funding formula have exacerbated shortages, and future Section 8 reductions have been proposed. Center on Budget and Policy Priorities, February 18, 2005, retrieved June 15, 2005: http://www.cbpp.org/2-18-05housapp.htm

[14] The number of cases for analysis varies by type of information. Some of the basic demographic, eligibility and housing data is available (in a de-identified format) for all 40 participants. Four of the 40 participants chose not to be interviewed or make their data available to CIMH. Final summaries were completed by clinical staff for 38 participants. Data collected by clinicians at two-month intervals during the study period is available for 32 participants. Thirty parents participated in the follow-up research interview. Participation in the follow-up interviews was reduced because, in addition to the four pilot participants who refused to participate in the evaluation at all, another four were lost to contact prior to the beginning of the interviews. Interviews could not be arranged with two other participants despite many attempts. Twenty-six persons participated both in the initial interview conducted by clinicians at two months into the program and in the follow-up research interview.

[15] Compare to 41% among homeless or at risk of being homeless among all CalWORKs participants. Bono, M., et al, op cit.

[16] The 53% never married compares to 51% statewide. Characteristics Survey. CalWORKs. Federal Fiscal Year 2002. http://www.dss.cahwnet.gov/research/CalWORKsCh_1450.htm

[17] Bono, op cit.

[18] Chandler, D., Meisel, J., & Jordan, P. (2005). *Outcomes of CalWORKs Supportive Services in Los Angeles County, Phase Two: Mental Health.* Sacramento: California Institute for Mental Health, 2030 J Street, Sacramento, CA 95814.

[19] Global Assessment of Functioning (GAF) scores at admission were compared for 32 Pilot participants with 323 randomly sampled CalWORKs mental health participants. The scale goes from 1 to 100, with 50 or lower indicating considerable impairment. The means were 50.4 for the Pilot and 48.3 for the random sample participants. The difference between them is marginally statistically significant: t-score=1.73, p=0.09. (Statistical significance tells us how likely it is that our findings might have occurred by chance, particularly due to random sampling differences. By convention we call "significant" a between-group difference that would occur by chance only one out of 20 times, i.e. , $p \leq 0.05$.)

[20] Chandler, D., Meisel, J., & Jordan, P., op cit.

[21] The questions referred to the 12 months prior to the interview date. For some this included some period of time prior to entering the Pilot.

[22] From the initial interview at two months into the program.

[23] The minimum time between the time participants entered the program and May 15, 2005 was 13 months; the maximum was 19 months.

[24] Reasons are diverse and include: lost to contact (1), serious medical condition (1), still looking for housing or in the process of finalizing a rental (3), did not find affordable housing so lost voucher (2), and moved into a five-year transitional program instead (1).

[25] Statistical significance is affected by sample size. With groups this small, differences have to be very large to be statistically significant.

[26] The means above are for all 31 clients for whom we have a two-month score and the 26 for whom we have a research interview score. A total of 22 clients took part in both interviews. Their means were 35.3 at two months and 42.3 eight to 10 months later (t-score –2.72, p<0.012.

[27] We used a standard two-item scale asking a) how many days the respondent had been totally unable to carry out activities of daily life, including work, and b) how many days the respondent had had to "cut down" on these activities. Kessler, R. C., Greenberg, P. E., Mickelson, K. D., Meneades, L. M., & Wang, P. S. (2001). The effects of chronic medical conditions on work loss and work cutback. *Journal of Occupational and Environmental Medicine*, 43(3), 218-225. The article describes the evidence for the way we used of relating the "unable" and "cut down" elements (i.e., to count each "cut down" day as .40 of an "unable" day and add that to the unable days).

[28] T-test comparing living in rental housing vs. shelter or other temporary housing: t-score=2.21, p=0.04. (Results from a non-parametric ranksum test were nearly identical.)

[29] We reported the BASIS-32 results in addition to these SF-12 findings because the BASIS-32 has 32 items rather than five, and is thus likely to be more reliable; the drawback is that there is no change score, hence the switch to the SF-12 and to change scores.

[30] The relationship between initial SF-12 scores and later housing status at follow-up was not significant; paralleling the BASIS-32 relationship, scores of the SF-12 at follow-up were significantly different by housing status at follow-up (One way ANOVA: F=4.06, df=25, p= 0.03.)

[31] This relationship is statistically significant in multiple regression analysis. Higher social support was also associated with positive change while the number of children in the family was associated with negative change.

[32] Overall, the rating for 1 person was worse at follow-up (3%), for 19 (59%) it did not change, and for 12 (38%) it improved. This a statistically significant change: t=-3.57, p=0.001. (A non-parametric ranksum test was nearly identical.)

[33] Not the same parents whose children were removed.

[34] Even early in the program high attendance was the rule.

[35] The four persons with a score between 35 and 44 have, based on national norms, a 27% chance of being unable to work; while the four persons with scores below 35 have a 57% chance of being unable to work. Ware, J. E., Jr., Kosinski, M., & Keller, S. D. (1995). *SF-12: How to Score the SF-12 Physical and Mental Health Summary Scales.* The Health Institute, New England Medical Center, Boston, MA.

[36] For disability days t-score=-3.03, p<0.01; for work skills t-score=-2.2873 p<0.03; for arrests, t-score =1.78, p<0.09.

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The California Institute for Mental Health is a non-profit public interest corporation established for the purpose of promoting excellence in mental health. CIMH is dedicated to a vision of "a community and mental health service system which provides recovery and full social integration for persons with psychiatric disabilities; sustains and supports families and children; and promotes mental health wellness."

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